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The current interest in using non-professional therapists to work with chronic schizophrenics is usually focused on the effect on the patients. Relatively little attention has been paid to the effect this particularly intransigent patient population may have on clinically unsophisticated students, especially students who are planning a career as professional psychotherapists. The questions is asked about the advisability of engaging naive students in the task of "helping" patients who are unlikely to exhibit identifiable behavior or personality change. Biographical and rating scale data from untrained student therapists are examined, and the conclusion is reached that in most instances, the experience has a positive outcome. Students attain insights into the nature of psychopathology and achieve a more realistic view of psychotherapy. The warning is issued, however, that the experience can be extremely frustrating and unnecessarily disconcerting to the naive therapist who expects but does not receive reinforcement in terms of a productive patient relationship or observable patient behavior change. It is suggested that unless considerable supervision is available a more responsive group of patients might provide a more suitable patient sample for the first therapeutic encounter. (Author)

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Psychotherapy and the Non-professional Therapist: Responses of Naive Therapists to "Therapeutic" Contact with Chronic Schizophrenics

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Since the publication of Rioch's (1963) groundbreaking work, increasing numbers of non-professional people are being used in therapeutic roles. Reflecting this interest are a number of projects which have examined the influence of college undergraduates on patient behavior, e.g., Hunter, (1966), Poser, (1966), and it is by now established that naive therapists can be helpful.

However, some further considerations need airing before the use of non-professionals as therapists is adopted wholesale. The first, and most important, is the effect the patients have on the students. Ethically the concern is generally reversed, but in view of the developing custom of using chronic schizophrenics as the treatment objects there is good reason to consider the potentially negative effects on the students.

The rationale for the use of chronic schizophrenics rather than a more responsive group is painfully obvious. The professional therapist by and large has scant interest in treating unresponsive patients, and since

chronic schizophrenics are the most regressed, they are also presumed to be the least likely to be damaged by student blunders. The paradox, however, resides in the assumption that the students, naive and unprepared for an encounter with the walking dead, will emerge from the experience feeling fully rewarded and still full of enthusiasm for the clinical enterprise.

The fact that Poser (1966) reports generally favorable patient responses to his students does not mitigate this concern. Change in chronic schizophrenics can be infinitesimal and still be classified as a positive outcome. One wonders about the degree of obvious behavioral change that occurred; was it sufficient to gratify the unrealistic expectations of an untrained and unexperienced person? Not likely, and if not, how do the students feel about themselves as therapists or prospective professionals? Do they emerge from the encounter wiser but still enthusiastic about psychotherapy and their own prospects as psychotherapists, or are they disillusioned about therapy and their own therapeutic capabilities?

Answers to these questions best come from the students themselves, and partially to this end a program involving student volunteers and chronic schizophrenics was conducted at the Brentwood Veterans Administration Hospital, Los Angeles, California. As part of a course requirement some of the participants wrote reports telling of their reactions and evaluation of the experience. Portions of this biographical data, together with self-report ratings on perceived "helpfulness" will be explored with the aim of developing some understanding of the range of outcomes which accrue to naive potential clinicians when their first clinical experience is with chronically psychotic patients.

Method

Sixteen UCLA undergraduates were selected from a group of volun-

teers all of whom were seniors and most of whom were psychology majors. The only requirement for entry into the program was that their time schedule be such that for 10 weeks they could appear at the V.A. for two hours in the afternoons of two alternate days of the week. The stated purpose of the program was to explore a new approach to the treatment of chronic schizophrenics. We were not concerned with personality reorganization as a therapeutic goal, and assurance was given to the students that, though we intended them to be therapeutic, they were not expected to "play therapist." Their major stated task was to interact and form relationships among themselves and the patients in as natural a way as possible according to the following format: the 16 students were divided into two groups of eight, one for a Monday-Wednesday group and one for a Tuesday-Thursday group. Each group of volunteers was assigned a patient from each of the two patient groups. The meetings were scheduled as follows: using a "leapfrog" technique derived from sensitivity training the first group assembled in a circle while the second patient group and the volunteers formed a circle outside the inner ring and observed those inside. After 12 minutes of interaction, the patients and their students assembled in "triads" which consisted of the two patients, one from each group, and the student. Three minutes of "feedback" occurred, followed by reassembly of the larger groups, but this time with either the second patient group or the volunteers in the center and the remaining members outside observing. This cycle continued until each group had been on the inside of the circle twice, usually consuming about two hours. The purpose of this particular format was to provide a situation whereby the students could serve as models for the patients, the patients and students could observe each other's behavior and exchange comments on their behavior, and the patients could relate to a presumably normal

person.

Ten of the 16 students, as part of a course requirement, were requested to write about their experience and to rate themselves on a six point scale of perceived helpfulness to their patients.

In order to examine in some detail student perceptions reported in the papers and still keep the amount of material covered to manageable size, three reports were chosen to represent the range of perceived helpfulness. The first report is by a student who gave herself a mid-point helpfulness rating of 3.5, and represents the average student. The second report was written by a student whose experience was most clearly negative (he gave himself the lowest rating, 2.5), and the third by the student who saw himself as very helpful (a rating of 4.5, the second highest).

Two of the reports, those from the students with the most and least positive experiences, are in diary form and excerpts will be reproduced verbatim. The report from the student who typified the balance of the student group will be paraphrased. The aim will be to extract from each report something of the sense of the learning which stemmed from the experience, as well as to provide a picture of the problems and pitfalls which can result from early exposure to a refractory patient group.

Results

Biographical material

The first biographical report is that of a female student who represented the view of the average student. This student Mrs. B., described her period of contact with the hospital and the patients roughly as follows.

Mrs. B., viewed entry into the program as a chance to find out what goes on in an institution, what institutionalized patients are really

like and whether she would like working with them, in the future, as a professional therapist. In short, she, like most of the students, were curious both about patients and her own suitability as a clinician. Her first impression, and she described it in devastating terms, was of the "grayness" of the institution. Components of that impression ranged from consciously averting her eyes from the toilets without doors to the sickness in her stomach following a lecture by a hospital representative on the rules and regulations of the institution.

A variety of events contributed to the learning experience of this student. One of the most significant can be found in her description of how she came to discover the economic purpose of the psychosis of one of her patients. Through a period of several meetings her patient had complained that he was totally incompetent and therefore could not be expected to live outside the institution. The patient attributed his feelings of helplessness to having learned (from an undisclosed source) that he had been diagnosed as a "chronic schizophrenic with paranoid tendencies" and "permanently disabled". It is difficult to say how destructive to the patient this discovery really was, but it became clear to Mrs. B. that at the least it provided the patient with an excellent rationale for staying in the V.A. This realization came one day when, after staring into space, he remarked in answer to her question about his thoughts that his was "just a typical schizophrenic stare, don't you know that?" Evidently the patient had an interest in maintaining his image of "crazy", a point which supports similar findings by Braginsky, Grosse and Ring (1960).

As she grew to know both of her patients better she also became aware of the loneliness of total institutions; she observed that she felt like

a master of ceremonies as she introduced two people who had been seeing each other for two years but who had never spoken. She was uneasy about the patients perceptions of her and the other students. Although she tried to avoid being a therapist and to remain merely the kind of human being she was, she felt that the patients responded more to her youth, education and sex, than to her personality. One of the patients stated that he felt inferior to her because of the obvious differences in age and education. She was furthermore sure that many of the patients resented the students; they felt that the students had no "experience", which she believed must have reduced the credibility of the student's behavior. She concludes by noting that although she "learned a great deal" about patients and hospitals, she was not sure that she had had any effect on her patients; they seemed to behave the same at the end as at the beginning.

The average student thus carried away from the experience some idea of the process of institutionalization and the love-have relationship many patients have with such places. They achieved some insights into the uses of psychosis as a defense against a more frightening reality as well as an increased sophistication about psychopathology. Finally, for those students who saw the experience as a maiden venture into therapy (and despite instruction to the contrary these papers suggest that most of them did), the romance of psychotherapy was shattered, an outcome we had anticipated with mixed feelings. While it may be useful to remove the illusions that psychologically unsophisticated potential clinicians possess about psychotherapy, experience with chronic schizophrenics is far from a fair portrayal of the range of possible therapeutic outcomes, and thus the disillusionment may be unnecessarily harsh. The answer to this dilemma rests on the type of learning the student is permitted to carry away from the situation. Left to him-

self to interpret the meaning of his therapy experience the student may distort the picture in a gratuitously positive or negative direction. As examples of both reactions the remainder of this section will be concerned with excerpts from the diaries kept by two of the male students. The first spells out the response of the student who was most articulately pessimistic about his experience and who saw himself as the least helpful of the participants. In a meeting-by-meeting chronicle the student, Mr. G., reports as follows:

Meeting I

"There's a big difference in the level of communication between the students and the patients. Students had an intellectual discussion of difficulties of communication. The patients don't attend much to what is going on".

Meeting II

"My patient contributed much... all irrelevant."

Meeting III

"I'm going good if I can get them to talk."

Meeting IV

"My patient spoke a lot... all irrelevant, but does show some curiosity in the students and their life, especially their education. Students are very bright and intellectual. If I talk to Harry, Frank interrupts... if I talk to Frank, Harry dozes."*

Meeting V

"One of my patients is gone. The other is glad to see me. Today one of the patients (not mine) said he was the "supreme commander of the American Army"... that's some aberration."

* The names are fictitious.

Meeting VI

"For the first time the patients' groups bore a faint resemblance to the student group. I began to speak of my own difficulties with acceptance and rejection... I feel like a loner. Several patients said the same thing. Except they said that they liked it... I said I didn't... Harry dozed."

Meeting VII

No entry.

Meeting VIII

"Harry left early. Frank still irrelevant. Some of the patients think he's a nut, but nobody says it. The trainer is at loss with him."

Meeting IX

"Harry stayed through to the end."

Meeting X

"Frank talked about how to make submarine sandwiches. I tried to talk to Harry during the triad and Frank kept interrupting. Is he jealous?"

Meeting XI

No entry.

Meeting XII

"Changed the format of the interaction at the request of one of the patients. Made me angry, because no one could see that the design of the experiment was being confounded. Began to feel alienated from the group. Talked with my patients but got no where... time is always too short."

With three meetings left this student felt rejected, helpless with his patients, and to some extent, helpless himself. He observed no changes in either patient, reporting at the end that "Frank is more subdued

and refuses to face himself and the world. Harry shows no basic changes. (in fact) He has tended to increase his withdrawal." The student observes further that "the project had more effect on me than on Frank or Harry. I realize that several of my perceptions are distorted by my own anxieties, and I realize this from the student discussions."

He supports Mrs. B.'s observation about the intellectual gulf that existed between the patients and the students when he says, "the students were supposed to supply a model of normal persons to the patients and also to demonstrate that normals have problems too. Yet these students are sophisticated, intelligent and young and tend to discuss problems like the "existential dilemma" and "the meaning of life." These ideas have little to do with Frank and Harry. I wonder whether the patients saw us as quite real or not... maybe more "normal" non-patients should be used."

His frustration is almost palpable. As he viewed it the students were not only ineffective as models for the patients, they were inappropriate. He saw no positive behavior change, and comments only on the signs of further regression. It is true that one of his patients became clinically more withdrawn during the group. The student felt helpless to arrest the withdrawal, and in this sense also responsible for what, to him, looked like deterioration. Although his interpretation of his own responsibility was based in large part on naivete, it is clear that the immediate outcome of the experience was negative for both him and his patient. Whether the long range consequences for this student will be positive seems to depend upon the use that he makes of the personal insights attained during the course of the program.

In contrast, the diary of the last student presents a rather poignant

picture of a successful attempt to establish contact with an otherwise unreachable patient. One of student W.'s patients was named Ken. Ken was an alcoholic who had shown few signs of emerging from the institution. He was the type of patient with whom few clinicians have much success, and Mr. W. was aware of this fact. He started his report with a somewhat over-drawn argument about the "middle-class" therapist's failure to meet and understand the "dirty people" of the world, i.e., lower class, alcoholics, etc. In this vein he spells out his decision to meet Ken on his own ground... in the tavern. He outlines his experience as follows:

"Ken was very suspicious of me on our first meeting. Doesn't trust me or the project. Gave me instructions where to meet him the next time, but he failed to show up for the next meeting.

"Next time I saw him I asked what had happened. He replied that he had waited for me for some time and then left. I let that go by."

"He wanted to leave early, but I wouldn't let him. He showed me around the grounds since we couldn't think of anything to talk about. We stopped and he said "can I buy you a beer?" I said "Sure."

"He suddenly changed. He smiled, and told me about the illegality of leaving the grounds (as we left the grounds).[4] He paid more attention to me as a person. He asked me about myself and commented on my answers. We had a relationship going."

"My willingness to break the rules seemed to tell him that I was on his side, that I cared more for him than the bureaucracy that made them."

"We drank 7 pitchers of beer at the tavern between 3:30 and 7:30 P.M."

"I remember the day with much emotion. It was one of the greatest

experiences of my life, for two reasons."

"First I got to know Ken. He told me who he was, what he liked and disliked, who his friends were. I tried as much as possible to just be myself. I was honest and accepting of him as a person. I cared about him and he accepted me in return."

"The second reason is that the experience seemed to confirm my belief that therapy ought to be performed in the patients' own environment. Ken was the Host at the tavern. He knew how to act there and he was comfortable. He had control and we were equals. He was a man. All the imitation therapy I did on hospital grounds was useless... after we drank together in his customary surroundings we were friends."

"Two days later when I met Ken he shook hands and had a warm smile. We went to a different bar. It was so bad it didn't even have a name. Shot a game of pool and Ken said he had decided to tell me why he was crazy. And he did. I suffered with him cause it was a bad scene, his childhood. He seemed like he would almost cry, then deny it. I quit trying to tell him how I felt and understood and just concentrated on listening."

"I agree that Ken has had a terrible past, but I can't see what in the world it has to do with his present "craziness." He's full of insight, but I can't see that it's done him any good."

"The group meetings have started. Ken sits there and looks bored. He was."

"Ken didn't show up for the fifth and sixth sessions. He was AWOL. I went after him. He was in the third bar that I visited, very drunk, very dirty and unshaven. He seemed glad to see me. We talked and drank beer for three hours."

"He said he left because a new psychiatrist had asked him why he drank and that he had got to thinking about it and finally figured it out. Except that knowing that made him want to go get drunk and forget it. He had written a 10 page paper on why he drank... it was beautiful. I got him to promise to go back. I had to leave to feed my monkeys at the university, but he said, "Who's more important, monkeys or people? I stayed."

"He tried to get me to promise never again to take a drink. I refused. He almost cried."

"Five days later at the next session he was a changed man. He became involved in the group, instructed the members to attend to their feelings, assumed leadership of his group and as a crowning achievement undertook to change the format of the sessions. He presented and defended his idea.... a vote was taken... he won overwhelmingly."

"As far as I can tell, Ken hasn't had a drink since he got out of the locked ward six weeks ago. Whereas before he went AWOL I smelled alcohol on his breath every day. I can't smell it now (and I try)."

"Why did he change? I'm not sure, maybe because I drank with him. Maybe I'll do my Ph.D. dissertation on it."

Very little needs to be added to this report except to note that unfortunately Ken did begin to drink again, although not with the dogged intent that existed before his encounter with Mr. W. One might fault Mr. W. for having been over-enthusiastic about his experience and with naively believing he had worked something of a miracle, but there is no question

that the experience exerted a positive force on his career plans and his view of himself as a clinician.

Discussion

What can be concluded from these reports? It is clear that the overall impact was for some exhilarating and for others deadening. On the positive side the students in coming to grips with themselves and the patients discovered a number of things about both. They discovered how tied up they were in their own methods of relating. They learned that their own behavior was different from that of the patients mostly in terms of the greater intellectual depth of their own conversation. The interaction for most of the students was little more meaningful than that of the patients in the sense of developing "deep" interaction among themselves. Their awareness of their own limitations, in the context of seeing themselves as models for the patients, apparently created a more tolerant perspective of the patient's interpersonal incompetence.

The students' interpersonal failures also included their relationships with the patients. Most saw themselves as frustrated because of their inability to engage the patients in "gut level" conversation. Out of this they became aware of the difficulties of communication and they now know that forebearance is necessary if they are to reach these patients. Most of them moved to a single mode of interaction, namely, a continous offering of themselves which the patients, at their discretion, could accept or reject. Attempts to force the interaction were quickly extinguished by

the patient's overt resistance to such tactics or his persistant use of his psychosis to avoid meaningful, i.e., coherent, interaction.

The significant feature of this response to frustration, however, is that all of the students were confronted with the reality of patients, hospitals and their own aspirations and anxieties. Some were forced to step back from a romanticized picture of their own helpfulness and the belief that patients could not resist their offerings. They moved from this position to an apparently more realistic appraisal of their task: how to establish a relationship with a psychotic person. They were more confused about their own capabilities to foster positive change. In short each was forced to re-examine exactly what it was he had in mind when he elected clinical psychology as his field of study.

The sum of the student's experience, as estimated from the papers, comments, and their requests for further similar experiences, seems clearly positive, but there is a negative side which needs careful consideration. Most of the patients with whom the students worked were refractory and stoutly resisted the formation of any but superficial, often socially incoherent, relationships. In their naivete most of the students viewed themselves as responsible for the failure in the relationship and carried away from the hospital a feeling of discouragement which ranged from mild to severe. Although most of them were eager for further clinical experience, they were quite uncertain about their capabilities as clinicians and change agents. Thus this kind of experience for students at this level of sophistication may have a distinctly negative impact. In its extreme it may lead to cynicism about the usefulness of therapy, hopelessness about psychotic patients and mistrust of their own capabilities to relate to patients (as

well as with each other).

Since nothing encourages like success or discourages like failure, especially with uncertain and unsophisticated people, it seems necessary to ask whether chronic schizophrenics are the most appropriate population for an introductory experience. If the professionals with their maturity and perspective are discouraged by patients who do not change, it seems probable that the non-professional will be even more profoundly affected. From the point of view of encouraging students to move into clinical psychology and ensuring a positive view of themselves as potential therapists, it may be advisable to expose them initially to a more responsive patient sample. Using more responsive patients for the first experience not only offers a good chance for a success experience, but represents the prototype of the patient treated by most clinicians. The disadvantages in using chronic schizophrenics are clear, although the supervising clinician can minimize the disillusioning impact of failure by intensive work with the trainees: preparation, supervision, and follow-up. The sense of this report is that exposure of naive therapists to schizophrenic patients demands careful preparation of the students in order to avoid the negative features which accompany this experience. Should this time and effort be expanded, then the exciting positive results may not only bring some of the patients closer to an experience with reality, but may also bring some of the students closer to eventually making a substantial contribution to the problem of treating the chronic schizophrenic.

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Abstract

The current interest in using non-professional therapists to work with chronic schizophrenics is usually focused on the effect on the patients. Relatively little attention has been paid to the effect this particularly intransigent patient population may have on clinically unsophisticated students, especially students who are planning a career as professional psychotherapists. The question is asked about the advisability of engaging naive students in the task of "helping" patients who are unlikely to exhibit identifiable behavior or personality change. Biographical and rating scale data from untrained student therapists are examined, and the conclusion is reached that in most instances the experience has a positive outcome. Students attain insights into the nature of psychopathology and achieve a more realistic view of psychotherapy. The warning is issued, however, that the experience can be extremely frustrating and unnecessarily disconcerting to the naive therapist who expects but does not receive reinforcement in terms of a productive patient relationship or observable patient behavior change. It is suggested that unless considerable supervision is available a more responsive group of patients might provide a more suitable patient sample for the first therapeutic encounter.

Footnotes

1. The authors wish to express their gratitude to the graduate students who acted as co-trainees and to the student volunteers who participated in the project.

2. The four groups of 8 patients made up the experimental group (N=32). Two other groups, a no-therapy control group of similar patients and a second control group of patients receiving intensive treatment were drawn from the same hospital ward. The 32 patients were selected randomly and randomly assigned to either the Monday-Wednesday or the Tuesday-Thursday meetings, 16 in each group.

3. This paper is based in part on results reported at the APA convention September 1966, New York.

4. Leaving the grounds with a patient to drink beer was a violation of hospital rules about which all of the volunteers had been informed; this one chose to ignore the instructions, which underscores another hazard in using untrained personnel. The fact that he apparently achieved a better relationship with that particular patient is worth noting, but it does not negate the desirability of aligning the implicit goals of the volunteer with those of the institution.